DOCUMENT RESUME

ED 375 360 CG 025 778

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TITLE Psychotherapy with Troubled African American Adolescent Males: Stereotypes, Treatment Amenability, and Clinical Issues.
PUB DATE 20 Aug 93
NOTE 16p.; Paper presented at the Annual Meeting of the American Psychological Association (101st, Toronto, Ontario, Canada, August 20-24, 1994).
PUB TYPE Speeches/Conference Papers (150) -- Information Analyses (070)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Adolescents; At Risk Persons; *Black Culture; Black Influences; Blacks; *Black Stereotypes; *Black Youth; Counseling; *Psychotherapy; Racial Attitudes; Racial Bias; *Social Bias
IDENTIFIERS *African Americans

ABSTRACT

The negative stereotyping of the African American male has a long and inglorious history. Even today, many therapists believe that African Americans are not psychologically minded, that they seem unmotivated for treatment, and that they lack the articulateness needed for successful talk therapy. These stereotypes largely arise from counselors' inadequate grasp of cultural knowledge about African Americans in general and African American youth in particular. Two cases are presented here which portray common and ignorant assumptions about African American culture. In both instances, the youths' race, size, history of aggression, and the therapists' failure to recognize strong motivating conditions, resulted in either a misdiagnosis or in an insensitivity to the patients' needs. When working with young males, therapists are encouraged to gain some knowledge of the communities in which the client lives (schools, gangs, churches) and the issues such as interpersonal violence, racism, cultural identity, and social problems, that young African Americans face on a daily basis. Instead of simply discussing multiculturalism, counselors must increase their efforts to become more knowledgeable and less judgmental about cultural differences, while confronting the prejudices inherent in the profession. Contains 13 references. (RJM)

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Psychotherapy With Troubled African American Adolescent Males: Stereotypes, Treatment Amenability, and Clinical Issues

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Presented at
101st Annual Convention of the American Psychological Association
Toronto, Ontario, Canada
Friday, August 20, 1993

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ABSTRACT

Historically African Americans have suffered from the negative stereotypes placed on them by the majority of society. Such stereotypes are found in the social science and treatment literature and can have a detrimental effect on treatment outcome. This paper focuses on how negative stereotyping effects the treatment of young African American males. The paper concludes with a challenge to the treatment profession to confront the prejudices in the profession and to become more knowledgeable and less judgemental about cultural differences. Finally, a more sincere effort is needed from the profession in order to provide appropriate treatment for young African American males.

Special thanks to Dr. Aombaye Ramsey for his editorial comments.

Special thanks also to Mrs. S. Rodgers and Ms. Ande Rodgers for their clerical assistance

The negative stereotyping of the African American male has a long and inglorious history. Europeans and European Americans have often compared the African American male to lower animals, described them as undisciplined buffoons, intellectual inferiors, and as having a propensity for violence (Akbar, 1984; Jordan, 1974; White and Parham, 1990). Such negative stereotyping has withstood the test of time and has affected African American males of every age social status, and geographical region. The portrayal of African American males as violent continues to this day. A recent college student survey revealed that 33% of Caucasian students in schools enrolling over 10,000 students or more have a physical fear of African American students (Elfin and Burke, 1993). A more popular example of the stereotype at work was during the two recent NCAA Tournaments in which the University of Michigan Basketball Team, led by five African American underclassmen, were vilified in the media as trash talking, undisciplined, style over substance underachievers. Foster (1993) accurately points out how race played a major role in this depiction, as much of the white media and many fans were taken aback by the cultural style displayed in the young men's play and dress. The team's two year record alone attests to their intelligence, their discipline, and their general ability to play basketball.

The social sciences have a long and disgraceful history of negatively stereotyping African Americans in general and males in particular. From Morton's early skull studies on so-called intelligence to the works of Jenson and Shockley,

the social sciences have perpetuated and attempted to validate the myths and assumptions held by the general culture about the inferiority of African Americans in general and males in particular (Gould, 1981; White and Parham, 1990; Wright, 1985).

In regards to the mental health literature, White and Parham (1990) point out that African Americans are often stereotyped as not being psychologically minded, as not being motivated for treatment, and as not being articulate enough to successfully engage in talk therapy. Although much has been written by African American theorists and clinicians regarding the treatment of African Americans (Bell, Fayen, Mattox, 1988; Boyd-Franklin, 1989; Franklin, 1989, 1992), generally white clinicians ignore and are unaware of this information and continue to be influenced by age-old stereotypes. In regards to the treatment of African American adolescent males, Hobbs (1985) points out the paucity of attention given to psychotherapy with adolescents in general and African American males in particular. She succinctly points out the issues that come to the fore for therapists in their work with this population. Other sources emphasize psychoeducational group techniques, with the focus placed on assisting young males in developing a knowledge, appreciation, and respect for their own cultural heritage, a connectedness to the community, conflict resolution, and personal responsibility (Lee, 1989).

Needless to say the negative stereotyping of African American males persists, especially in the various mental health facilities with which members of this

population come into contact. In the various settings within which I have worked (private community mental health facility, juvenile court clinic, training school, children's psychiatric hospital), it has been quite evident that the treatment provided for African American adolescent males has been influenced by the attitudes and stereotypes and lack of cultural knowledge of the institution's treatment providers. The young male has been perceived as a "good boy" who is in need of understanding, as potentially violent (due to either innate or environmental factors), not psychologically minded, not verbal enough to engage in talk therapy, and at best minimally amenable to treatment. However, this has not been my experience with this population. Of the vast majority of youth I have had in therapy, I have found them to be quite verbal, insightful, perceptive and intelligent. However, in nearly every case the individual was not considered to possess these attributes upon initial evaluation. One of the major reasons this is so is again the lack of cultural knowledge about African Americans in general and aspects of African American youth culture in particular. The following two case studies serve to exemplify the fore-mentioned issues.

CASE I

Gregory was a relatively tall, muscular fourteen year old African American male upon admittance to the hospital. Prior to his hospitalization, Gregory was in a group home facility where he had frequently truanted, fought with other residents, stole the facility van (eventually bringing it back), and had been generally disruptive.

While in the group home Gregory began telling the staff that he was hearing voices (these voices were telling him to shoot people, sell drugs, etc.) and that he was having hallucinations. Gregory was placed in the fore-mentioned facility, diagnosed as chronic paranoid schizophrenic and placed on psychotropic medications. Upon his transfer to the long term facility, he was initially taken off medications and was assigned to me as a therapy case. In our initial meeting I queried Gregory on where he grew up, who he "hung with," his family situation, etc. He appeared somewhat impressed with my general knowledge of his geographical area, and some of his previous placements. Gregory then asked me what public transportation was available near the hospital. When asked if he was planning to go somewhere, Gregory laughed. I then commented that he was not "crazy" but was just "fronting" (faking). I then questioned Gregory as to how and why he got into the mental health system. Gregory then explained how one of his group home peers had advised him that the mental health system was "easier" to deal with and that it was also easier to escape from. He was also advised as to how to look and to sound "crazy." Gregory commented that he was planning to truant from the short term facility but was too "doped up" to make his move. I commented to him on his being inappropriately placed and inappropriately diagnosed and that it was my responsibility to get him moved to an appropriate placement. I informed Gregory that while he was in the hospital we would meet regularly for therapy.

The therapy goals were to address Gregory's relationship with his mother,

address his negative value system, increase self awareness, and get him properly placed. Gregory stayed in the hospital for several months as I fought with department of social services bureaucracy and the agency's general ineptitude (DSS felt that Gregory had been labeled schizophrenic by other "experts" and was reluctant to consider the diagnosis and recommendations from this therapist).

While Gregory was in the hospital, he and I attempted to address the fore mentioned therapy issues. Gregory admitted to being drawn to a negative lifestyle and not wanting to give it up. I attempted to help Gregory begin to see the impact his behavior had on his family relationships, and attempted to help him see alternatives in light of his intelligence, and general abilities. I also spoke to him on the real consequences to himself as a result of his behavior (at the time Gregory had only received minimal consequences for his negative behavior). Throughout his hospitalization I made it very clear to Gregory what my recommendations would be. Because Gregory was delinquent and not schizophrenic, another group placement would be recommended. If he chose to act out in that placement then the recommendation was for him to be prosecuted to the fullest extent of the juvenile system. If Gregory complied with the recommendation it would be further recommended that he receive remedial assistance for basic academic skills and that he, his mother and stepfather be involved in family therapy on an outpatient basis.

DSS agreed to the recommendations and Gregory was being considered for a group home placement. However, placement was still several months away.

Because he could not go home, Gregory had to stay in the hospital. While hospitalized, Gregory was covertly disruptive, he would intimidate certain peers, undermine certain staff, and was implicated in petty vandalism. However he was very appropriately helpful to certain peers and generally followed the directives and accepted the limits placed on him by myself and the recreation director (another African American adult male). On the day Gregory was to go into placement (though unknown to him) he truanted. He went home and after a few days his mother took him to the placement. Gregory initially made an adequate adjustment, but eventually returned to the streets, got reinvolved in criminal activity and was eventually arrested. He is currently in a delinquency facility.

Although Gregory's treatment could not be considered generally successful, his case points out several important issues. Firstly he was misdiagnosed. He was not schizophrenic but delinquent. It is my opinion that his race, size, history of aggression and superficial reports of hallucinations significantly influenced the white professionals who initially evaluated him, and he was quickly labeled a schizophrenic. From the content of the "voices" Gregory heard, the possibility of malingering should have been considered, especially in light of his background. Gregory also made the claim of being a devil worshiper, which was another sign since such practices are extremely rare in the African American community, given the general strong influence of traditional religiosity in African American culture (Boyd-Franklin, 1989). Gregory had little to no knowledge about devil worship

practices, but was not previously investigated. Gregory was also more willing to relate to those whom he could not easily intimidate, and who challenged him along with showing an interest in him. It is my opinion that Gregory gravitated toward a negative lifestyle by possibly being influenced by various relatives and peers. He made a choice as to what he wanted to do, believing that he could skirt the consequences of these actions. However it should be clear that he was misdiagnosed and misplaced based solely on underlying stereotypes and assumptions about African American males.

CASE II

Upon admission to the hospital, Jerry was a 16-year old 6'3", 365 pound youth who was diagnosed as a major depressive with psychotic features. Jerry reported homicidal ideations directed toward family members, and a history of auditory and visual hallucinations. Upon initial presentation Jerry appeared aloof, quiet, and sullen. Reportedly he was not interested in any activities and would not talk much. At our first meeting I began to explore the homicidal ideations, and his history of hospitalizations and treatments. We also discussed the area in which he grew up. Prior to meeting with Jerry the staff informed me that Jerry was overweight though generally in good health. When it was suggested that he get involved in a weight reduction program or general physical activity he declined.

As I spoke with Jerry about general issues, I interjected information about African Americans, hypertension and heart disease, and the fact that his weight

could put significant pressure on his joints (Jerry complained about soreness in his knees). I spoke to him about how diet and exercise can be helpful for him. He agreed to do this and over the course of his hospitalization he was involved in these activities. In our initial sessions discharge plans were also discussed. Jerry commented that he would like to return home. I commented on his desire to go home given his ideations, and asked if he had a child who wanted to kill family members, would he let him back in the home? Jerry smiled and stated he got my point.

Jerry and I discussed treatment goals. They were to alleviate his depression, improve his self esteem, and improve his relationship with his parents. Jerry proved to be quite verbal but had difficulty discussing feelings and identifying issues that were troublesome for him. Eventually Jerry was able to discuss hurt feelings around experiences while growing up. Many of the feelings related to his size (Jerry was always described as being "big" for his age). Jerry was often challenged by older children who wanted to fight him because of his large size. He was also prodded by others who thought he should be a bully because few people would be able to stand up to him. However, Jerry did not have this demeanor.

Jerry was often depressed while growing up and was frequently in outpatient and inpatient treatment. As he grew, he got more and more involved in fantasy role playing games, and comic books and gradually withdrew from others. He began to report visual hallucinations and had difficulty relating to family members. Hence the

many hospitalizations.

Throughout his hospitalization Jerry had brief periods of mild depression that he was able to discuss. There were no more reports of hallucinations nor of homicidal ideations. He also appropriately discussed angry feelings, his self concept, and family relationships. During regular treatment team meetings various staff would comment on Jerry's sullen, "mean" demeanor, their difficulty communicating with him, and fears that he might "blow." These concerns were in contrast to my own and also to Jerry's school mentor, the shop teacher, one of the only three African American male school staff persons. It was accurate that Jerry would only talk to certain staff, many others he would only relate to on a superficial level or just enough to get the basic information he needed. When this issue was addressed with Jerry, he stated that his past experiences in treatment made him wary of talking to many professionals. When asked why he talked to this one, Jerry stated that I treated him like a human being. That not withstanding, therapy focused on helping Jerry to appropriately relate to adults whether he liked them or not, and recognizing how people may perceive or misperceive him because of his size and race. Jerry's size was often commented on by various staff members. He was referred to as "'big fella," "Huey," "big boy," etc. Once while walking with me a staff member commented that I "had a big one." My first inclination was to point out to various people how insensitive these comments were, but I quickly decided to discuss this issue with Jerry and help him to address it. Jerry initially stated that the

comments did not bother him, but I pointed out how I noticed a change in his demeanor when such comments were made. I tried to assist him in expressing his feelings about such comments and pointed out how he would allow his anger to seethe over this. I assisted Jerry in learning to appropriately address such comments by both adults and peers. Jerry was soon successfully handling these situations, and such comments were significantly reduced.

Throughout his treatment Jerry and I discussed being a young black male in this society and stereotypes related to his size and complexion. Jerry proved to be one of the more mature and perceptive patients in the hospital and after a while this was often commented upon by other staff members. His relationship with his family improved with the aid of family therapy. He was eventually discharged home. He re-enrolled in the public school system and is projected to graduate this summer. His immediate plans are to enroll in a community college.

Jerry's case points out how his size and race negatively shaped others' perceptions of him. Though Jerry tried to protect himself from these perceptions by being sullen and withdrawn, this only served to further negative perceptions and prevented him from receiving the necessary assistance on many significant issues.

Jerry's comment on being treated as a human being merits attention. Often clinicians speak about "cases" as in "this is an interesting case," "this is a difficult case" or "this is a good case for a student." If we are not careful we can lose sight of the individual and address "the case." This appears to have been Jerry's

experience, coupled with the negative stereotypes previously expounded upon. Both factors dehumanize the individual and are detrimental to the treatment process.

There are many clinical issues that arise from working with African American males and African Americans in general. It appears that the treatment profession still pays lip service to the goal of multiculturalism and is still ignorant of the cultures of people not of the majority population. Lacking a knowledge of the people one may attempt to treat, only serves to set up a significant road block to accurate diagnosis and appropriate intervention.

For instance, when working with young males it is helpful to have some knowledge of the communities in which they live (i.e., what schools are in the area; what gangs, if any, are in the area; how active are the area churches; what community resources are available). General issues young males are confronted with are the impact of interpersonal violence, developing a cultural identity, confronting racism, defining manhood, being a teen father, social problem solving, and male/female relationships. Of course this list is not exhaustive but it exemplifies the complexity involved in working with young African American males, and the need for significant changes on a societal level.

As a profession, psychology needs to expand its worldview, become more knowledgeable about cultural differences and confront the prejudices inherent in the profession. Psychology needs to make a commitment to better serve a culturally and socially diverse population. If psychology does not make the effort to meet this

challenge, then the claim of being a helping profession is just so much hypocrisy. Or, to paraphrase a young urban dwelling African American male; when it comes to helping "y'all jus perpetratin'."

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